

**Financial Effects of Defensive Medicine and Medical Malpractice Insurance**

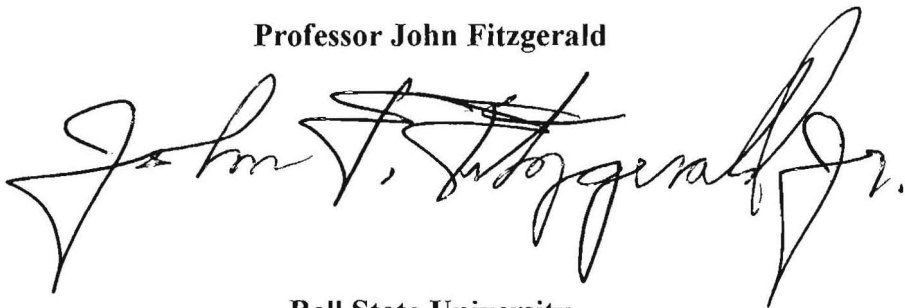
**An Honors Thesis (HONRS 499)**

**by**

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A handwritten signature in black ink, reading "John T. Fitzgerald". The signature is fluid and cursive, with a large, stylized initial "J" and a prominent "F".

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### **Abstract**

Although all Americans may utilize, benefit from, and complain about healthcare, few actually understand the underlying costs. It is easy to blame politicians, large hospitals, or greedy physicians for our nation's current healthcare crisis, but they might not be at fault. Through analyzing two aspects of healthcare costs—defensive medicine and medical malpractice insurance—I hope to give the average American the ability to understand how both of these factor in to what they are paying for healthcare.

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As healthcare prices continue to rise and insurance coverage continues to shrink many Americans have begun to wonder where we went wrong. Whose fault is it that the average American can't afford private health insurance? Or that Medicare will soon cost more than the taxes bring in? Will the new Obamacare solve these problems? Unfortunately, there is no clear answer to these questions and only time will tell whether or not any current legislation will improve the situation. By looking at individual factors of healthcare costs one can pinpoint changes that can make a difference. Defensive medicine and medical malpractice insurance premiums are two contributing factors to the cost of healthcare. However, whether or not changes in both or either will significantly make a difference is debatable.

Defensive medicine is not a new concept. For over thirty years, physicians, researchers, and government officials alike have claimed that defensive medicine is the most expensive aspect of the medical malpractice system (OTA, 2). The Health Insurance Association of America reported in their 1975 study that defensive medicine creates between \$3 billion and \$6 billion in health care expenses annually (Tancredi, 879). Unfortunately, it is quite difficult to measure the impact of defensive medicine on the cost of medical care in the U.S. today. Most often, surveys of physicians are used to estimate defensive medicine usage, but the surveys lack the ability to measure the unconscious acts of physicians. This become problematic as a physician may at first realize that ordering an extra test is to both help in diagnosis and limit their potential liability, but as this practice continues it will eventually become an ordinary part of their routine and therefore not reported as a defensive measure. Such studies generally consist of surveys sent to physicians asking what their actions would be in clinical scenarios and why they would choose these actions (liability risks being a possible explanation). These surveys are

generally considered less than reliable, having a nonresponse bias due to their response rate of less than fifty percent (OTA, 47). Physician surveys are conducted to show all defensive medicine.

Today, defensive medicine is primarily divided into two categories: positive and negative; this is not to say that positive defensive medicine betters the healthcare industry and negative defensive medicine is the root of all problems. In fact, negative defensive medicine has only a minute effect on the overall cost of healthcare for patients (Tancredi, 879). Positive defensive medicine, characterized by an increase in diagnostic testing, referrals to other doctors, follow-up appointments, charting, or written informed consent, benefits the health of the patient overall (Summerton, 27). Positive defensive medicine is the most used type of defensive medicine, but it is also a major contributor to the rise in healthcare costs around the nation (Summerton, 28). Unfortunately, this cost is borne first by the health insurer and then eventually, through rise in premiums necessary to continue a profitable business, the insured (Quinn, 472). The aforementioned surveys have shown that less than eight percent of diagnostic tests are ordered with the reason being conscious concern of liability (OTA, 1). Some believe a more realistic definition of positive defensive medicine is limited to “provision of services for which the added cost is less than the anticipated benefit” (Sloan and Chepke, 54). This is a critical definition because if the extra diagnostic tests ordered or the added physicians’ time in charting and note-taking provide a benefit greater than the cost (such as an extra test finding cancerous cells in their early stages), then it is not technically defensive medicine. Another condition for defining an act as “defensive medicine” is that its primary reason is to avoid malpractice risk, but this may not be the only reason the physician chose to do it (OTA, 3).

Just as positive defensive medicine is generally considered positive for a patient's health, negative defensive medicine has an overall negative effect on the patient's health and well-being. Negative defensive medicine is commonly defined as avoiding risky treatments or refusing to see patients that are more likely to result in a lawsuit (Tancredi, 879) (Summerton, 27). It is often thought of as revenue-reducing defensive medicine because physicians will drop riskier portions of their practices (especially obstetrics and high-risk surgery), thus reducing their potential revenue (Quinn, 471). This can unfortunately lead to overutilization of simple procedures to boost revenue. Over thirty-four percent of physicians refuse to accept cases which they deem to involve "risky procedures" (Zuckerman, 131). High-risk patients incur greater healthcare costs as a result of such rejections, at the same time the physician's medical malpractice premiums decrease for dropping the risky procedures. This is a double-edged sword in the healthcare crisis and one for which lawmakers have not yet proposed a solution. Negative defensive medicine frequently hurts the patient because it makes the process of finding qualified and geographically close practitioners, especially for obstetricians and other high-risk specialties, extremely difficult and often stressful. Whether positive or negative for the patient, all defensive medicine benefits the physician—economically and psychologically (Hermer, 470).

Each physician's acceptance, use, and definition of defensive medicine is unique and heavily influenced by their education and experience. In a 1995 study published in the *British Medical Journal*, Nicholas Summerton found a direct correlation between a physician's worry of being sued and their practice of defensive medicine (28). The more threatened a physician feels, the more likely—and willing—they are to go to defensive measures to protect their reputation. This explains why a 2005 study of Pennsylvania physicians, classified as working in high-risk specialties, found that ninety-three percent admitted to using defensive medicine on a daily basis



in their work (Hermer, 470). The problem is the line between customary practices, or the standard of care, and defensive medicine is not set in stone. (Tancredi, 881). The style in which residents practice medicine—their use of defensive medicine—is largely established by the specific doctor who trains them—their mentor (OTA, 36). Unfortunately, whether the physician sees the practice (that which causes more harm physically or economically than the benefit it provides) as defensive or standard care it still increases healthcare costs. Overall, most physicians admit to practicing defensive medicine in one form or another. Physicians practice various forms of defensive medicine to help lessen their risk of a malpractice lawsuit (Zuckerman, 131), (Reed, 207):

- 57% have improved their record keeping
- 44% have referred more patients to a specialist
- 40% have ordered more diagnostic tests
- 35% have spent more time with patients
- 27% have provided additional treatment measures
- 74% have spent a greater amount of time writing clinical notes than if there was no fear of a lawsuit

It is easily seen that defensive medicine is in fact a frequent and reoccurring practice in today's healthcare field.

No physician wants to be sued. In fact they, just like most individuals, will go out of their way to please a patient and not have to deal with a lawsuit. Those who have been sued are more likely to practice defensive medicine to decrease the risk of another suit against them (Tancredi, 880). A small increase in precaution, practicing defensive medicine, can result in a large decrease in expected liability (Kessler, 358). The most damaging part of a malpractice suit is the

loss of reputation, not the time and money spent on defending their practice. This reputational loss is uninsurable, career damaging and enough of an incentive for most physicians to use defensive measures in their practice (Quinn, 471). All other aspects of medical malpractice suits are insurable and of no cost to insured physicians beyond the premium (Sloan and Chepke 71). Reputations are tarnished primarily by word of mouth with media often at the heart. One Washington, D.C. consumer group publishes lists of physicians deemed by the organization to be the defendants in an unreasonably high number of lawsuits. Depending on the number and severity of claims, many television stations and newspapers also do stories on suits filed against local physicians (Quinn, 469). Although for the physician with only one or two small claims on his/her record the medical malpractice premium increases and media backlash may be minimal or nonexistence, many others are not so lucky. Eighty-six percent of physicians believe that just being named in a suit, no matter whether or not the suit actually makes it to court, has a lasting negative effect on their reputation and personal lives. Sixty-seven percent of the same group of physicians believe that lawsuits have a negative effect on patient-physician relationships (Reed, 207). This can be an unfortunate, yet continuous downward spiral; as relationships with patient begin to fade in importance to physicians, patients are more likely to bring suit against their physicians.

A survey of women after giving birth showed that the women blamed their physician for forty-four percent of any adverse effects of the process, hospital staff for seven percent, themselves (patient) for ten percent, and left the other thirty nine percent of the blame to chance. Those with positive doctor-patient relationships throughout the entire experience reported less intention to file a claim against the physician and hospital (Moore, 248). Physicians must thus get to know each patient in order to avoid unnecessary lawsuits. Patients should know and

understand the purpose of each procedure performed. University of Michigan Health System's chief risk officer, Richard Boothman, believes that the cure to the current medical malpractice crisis is improving patient safety and communication (Science News, 2). Local/small town physicians must work especially hard to please their patients as patients believe they are more likely to make a mistake than physicians in a more "prestigious" job (McQuade, 409). Also, patients with increasing wealth and education are less satisfied with their medical care and more likely to file a malpractice claim (Moore). To overcome these obstacles physicians need to know each patient personally and understand exactly why they are in their care.

Defensive medicine is seen as a positive practice primarily by those rare patients that benefit significantly from the extra tests and procedures. Cesarean deliveries and the management of head injuries in emergency rooms are highly influenced by defensive medicine (OTA,2). A survey of physicians named a scenario of a "15 year-old boy with a minor head injury from a skateboard accident" with the greatest prevalence of conscious use of defensive medicine. Fifty percent of the physicians surveyed stated they would order a CT scan, and forty-five percent of those stated defensive medicine as their primary reason for doing so (OTA, 5). Defensive medicine has also been cited as the primary reason for the recent increase in C-section births. Birth related lawsuits tend to be the most expensive malpractice suits because of their nature and life-long effects. Cesarean sections carry with them the same risks as any other surgery, often not completely considered (Tancredi, 881). In its 1994 study of defensive medicine and medical malpractice the congressional office of technology assessment found that nearly nine million dollars was spent each year on defensive Caesarian deliveries (OTA, 8). These instances of defensive medicine primarily benefit the physician.



Doctors believe the current medical malpractice liability system is at the heart of defensive medicine and many healthcare cost problems. The goal of the system is “providing redress to individuals who suffer negligent injuries creating incentives for doctors to provide appropriately careful treatment to their patients” (Kessler, 353). Basically the idea is that by taking negligent physicians to court other physicians will work to not make the same mistakes. Unfortunately, it is shown that the current system is not suited for preventing such injuries and compensating victims competently (Sloan and Chepke, 1). There is currently only a minor connection between the negligent acts of physicians that are detrimental to patients, and results that cause lawsuits (Hermer, 471). This means that many negligent physicians have no consequences and therefore continue practicing negligently. For those patients who believe they were victim to negligent care their claim may or may not ever make it to trial, and those that do often take years to reach a verdict. Nearly twelve percent of claims take more than eight years to be resolved. This phenomenon makes setting medical malpractice premiums, which are meant to cover expenses for the given year, extremely difficult for the insurance carriers (Thorpe, W4-22). Overall, the severity of malpractice suits has been steadily rising since the early 1970’s. This rise in jury awards, along with many lawyers’ contingency fee structure, has created an environment for frivolous lawsuits (Thorpe, W4-21). Lawyers continue to take on cases and fight for the multi-million dollar jury award even though a menial number of medical malpractice lawsuits result in a verdict against the named physician. As litigation continues in this manner, it becomes less beneficial to the quality of medicine and the health of the healthcare industry as a whole (Charles, 437). The medical profession must be willing to discipline its members, or it too could end up similar to the financial industry and need the government to bail them out (McQuade, 409).

Medical malpractice costs, especially the steeply rising premiums, are often cited as a critical reason physicians practice defensive medicine. The growing severity and frequency of lawsuits has forced medical malpractice insurance carriers to take a huge hit financially and, as a result, raise their premiums substantially. During the second such medical malpractice crisis, in 1983, carriers reported \$750 million in underwriting losses for just that year (Zuckerman, 128). Insurers reported an overall loss again in 2002. For each dollar they earned in medical malpractice premiums, insurers incurred one dollar and twenty-nine cents in expenses, a drop in after-tax income from twenty-three percent to negative eleven percent in just one year. These expenses included administrative, legal, settlements, and awards paid (Thorpe, W4-22). Although the lawsuits may not result in any out-of-pocket expenses sustained by physicians, for most the resultant premium rises cause an increase in overhead costs. Physicians and hospitals must pass these extra expenses on, just as insurance carriers must pass their losses on, usually to patients, taxpayers, and premium payers (hospitals or physician groups) (Tancredi, 879) (Sloan and Chepke 61). For many insurance companies, hospitals, and physicians the rising costs of malpractice liability has become too much. The St. Paul Company, which was previously the nation's largest medical malpractice insurance carrier, left the market entirely after the 2002 losses (Thorpe, W4-20).

An often overlooked and overshadowed cause of medical malpractice premium increases is the decrease in interest rates (Thorpe, W4-21). Insurance companies invest physician's premiums until they are needed for claims payouts; this provides carriers with an additional source of income and ability to offer insurance at a reduced rate. As interest rates have decreased with the nation's impending financial situation, this additional source of income has also dwindled.

Healthcare is currently a hot issue politically. Whether or not these premium increases are a basis of defensive medicine is debatable. Medical malpractice premium rates are often cited as a cause of the steep rise in healthcare prices. In actuality the malpractice liability systems, including insurance premiums, court costs, and payouts, account for only 1.5 percent of the nation's total healthcare costs (Hermer, 471). If the price of medical malpractice premiums were to decrease by ten percent the cost of medical care would only fall by .132 percent (Thomas, 1578). This may come as a surprise to much of the American population. A 2006 survey of small business owners found that nearly seventy-one percent believed rising malpractice premiums were at the root of growing healthcare costs (Morrisey, 2125). Unfortunately, malpractice litigation as a whole is not entirely innocent in the healthcare crisis.

As doctors take their time and resources away from practicing medicine to deal with malpractice lawsuits they lose money primarily in lost income (Zuckerman, 128). In order to make up for these costs, they must raise prices. A 1983 survey done by the American Medical Association's Socioeconomic Monitoring System found that roughly thirty-one percent of physicians had increased fees due to malpractice costs. During the five year study from 1978-1983 it was found that each claim filed against a physician caused them to be away from their practice for 2.7 days at a loss of \$1,065 in possible income (Zuckerman, 131). A 1994 survey shows a claim to cost a physician anywhere from 2.5 to 5 days and between \$2,400 and \$5,600 in missed income (OTA, 27-28). In today's economy that number would be much higher. Thus, as the number of claims filed increases the cost of healthcare consequently follows. Between 1956 and 1990 the number of claims per 100 physicians rose from 1.5 to fifteen (Thorpe, W4-24). So, although malpractice premium increases are not at the root of the healthcare crisis, they



do negatively affect physician's expenses. At the same time it is difficult to decide which is more damaging in terms of costs to the patient—defensive medicine or malpractice lawsuits.

Tort reforms, changes in the civil justice system, allow state governments to essentially lower malpractice insurance, with hope that the effect will trickle down to healthcare costs. Medical malpractice tort reforms first came into play during the malpractice crisis in the mid-1970's. They gained popularity again during the next similar crisis in the mid-1980's (OTA, 11). Both of these times were deemed crises because of the sharp increases in premiums, similar to what was seen more recently in 2002. By implementing tort reform laws states hope to do one (or all) of the following (OTA, 11):

- shorten statute of limitations
- limit attorney fees for plaintiffs'
- implement pretrial claims screenings
- caps on damages
- changing the collateral source rule by allowing/requiring award to be reduced by amount paid through insurance
- structured settlements instead of lump sum payments

The most common types of tort reform are caps on damages and collateral-source-rule; both directly reduce jury awards (Kessler, 360). The overall purpose of such tort reforms is to lower malpractice premiums in attempt to make the medical malpractice system less hostile towards physicians (Quinn, 18). For the most part states have had favorable results causing more states to begin implementing similar tort reforms. Loss ratios are 11.7 percent lower in states which cap rewards, 13.3 percent lower in states with collateral offsets, and for states with both, twenty-five percent lower. States are able to reduce both medical malpractice premiums and healthcare expenses simply by capping rewards. In 2003 premiums were 17.1 percent lower in states that



capped possible rewards (Thorpe, W4-20). In 2006 twenty-eight states had some type of law limiting malpractice case payouts, reducing their healthcare expenses by more than three percent (Hellinger, 6). Although one can easily see that these reforms have effectively lowered malpractice premiums for physicians, it is important to ask, at what cost to the patient? As these reforms limit a physician's possible lawsuit expenses and consequently total liability, they could be negatively affecting the quality of medical care received (OTA, 75). Without punishment for negligent acts physicians may continue without realizing the harm they are doing.

Essentially, tort reforms are implemented to decrease healthcare costs by reducing defensive medicine (Hellinger, 7). It seems simple that as possible rewards are lessened, amount of suits filed will decrease, and perceived threat of a suit filed will also decrease with the end result being physicians practice less defensive medicine. Unfortunately, there is little evidence that tort reforms in fact do make a difference in the amount of defensive medicine practiced by physicians (OTA, 11). Three common goals of tort laws are (Sumner, 1):

1. Stop doctors from operating beyond expertise through use of medical malpractice suits
2. Penalize those who practice low quality medicine
3. Settlements/payouts for patients injured from low quality/negligent care

In order for the tort system to be successful in deterring harmful care by physicians it must set guidelines of acceptable care and have the ability to improve the care currently being offered (OTA, 29). Therefore tort reforms must implement a standard of care and at the same time allow claims and resultant lawsuits to improve the quality of care. Unfortunately, neither of these are the existing reality.

Malpractice suits are widely known to increase physician's financial woes, but the impact on their emotional state is rarely analyzed. Defensive medicine is not purely practiced to save

physicians from excess financial worry, it is also important for their psyche. Sued physicians are generally more likely to be depressed, have inner tension, anger, and frustration of the medical field compared to those which have never been sued (Charles, 438). Physicians who have only been sued once may not see a major change in their personal or professional lives (OTA, 10). A questionnaire study of physicians in 1985 showed that those whom had been sued were (Charles, 440):

- 48.9% more likely to discontinue seeing high-risk patients (negative defensive medicine)
- 42.9 % considered retiring early
- 32% discouraged their own children from choosing a career in medicine

Family physician Dr. John Findley explained that the current complexity of modern medicine makes it impossible for individual physicians to deliver safe care; there are over 6,000 known diagnoses and 4,000 known drugs. Physicians must admit to not having all the answers and be willing to work with others (Kondro, E645). By admitting their weaknesses physicians can lower their liability and defensive medicine use. Their ultimate goal, driven by malpractice fear, is to practice at low levels of medical uncertainty; a level of medicine where the benefits are typically low and the dollar cost high (OTA, 1). As practicing medicine continues to become more complex the stresses involved cause many physicians to do whatever necessary to practice with the lowest possible risk—defensive medicine.

As lobbyists and lawmakers alike already know, healthcare is an extremely difficult and complicated issue. Yes, defensive medicine is practiced by most, if not all, physicians in some fashion. Yes, it is known to generally increase the cost of a patients' healthcare more than the benefits a patient reaps. Yes, there are ways to combat its usage, but just how much of a difference is plausible? Who's decision is it that just because a diagnostic test for example only

discovers cancer, that has not already been detected, in 1 out of every 1,000 people it is not worth the cost. Defensive medicine is a difficult issue. Tort reforms are improving the situation, however, not as well or as fast as needed. Without a clear set of practicing guidelines and definition of defensive medicine it will be nearly impossible to reduce errors and healthcare costs. So although unnecessary defensive medicine practices and medical malpractice premiums may not be at the sole of the current healthcare crisis they are contributing factors and by reducing their financial impact a difference can be made.

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